PSYCHOLOGY CASE RECORD

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By

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CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Juhi Rachel Baluja** during the years 2016-2018. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD – 1: Personality Assessment

Name	: Ms MH
Age	: 18 years
Gender	: Female
Marital status	: Married
Language	: Hindi, English and Bengali
Education	: 12th Grade
Occupation	: Housewife
Socio-economic status	: Middle
Residence	: Semi-urban
Informant	: Mrs MH and her mother-in-law

Presenting complaints

- Frequents quarrels with husband and in-laws
- Low mood
- Lack of motivation
- Suicidal threats
- Decreased socialisation

History of presenting complaints

Mrs MH is an 18 year old married housewife from a poor, rural background from West Bengal. She is the second of three sisters and described as someone who's ambitious and extroverted. She presented with complaints of having constrained relations with her husband and her in-laws. It was an arranged marriage and since the beginning, she was not in favour of it, as her husband happened to suffer from mild intellectual disability with dismorphic features. She, on the other hand, wanted to study further and be independent and have a job, but her family's poor financial conditions failed to provide her for that. As much as she protested about it to her mother, in the form of excessive crying and threats to end her life, but she couldn't go against her father's decision and gave in. The first few months of marriage were very difficult for her to adjust. She did not enjoy sexual relations with her husband and avoided them as much as she could. With her in-laws, she tried to blend in with the new environment, but often faced criticisms for her household chores. All this, combined with the inability to study further, made her very frustrated and she began getting into frequent arguments with her husband and in-laws. With much insistence and difficulty, her in-laws agreed her to study up to 12^{th} grade. However, she continued to be unhappy as her ambition to study more remained. Also, there was a pressure for her to have a child, to which she was not willing. Therefore, the fights continued and she lost interest in her day to day activities.

There is no history of any organicity around the time of onset of her symptoms.

There is no history of any first rank symptoms in the past.

There is no history of any manic or hypomanic symptoms in the past.

There is no history of any obsessive-compulsive symptoms in the past.

Treatment history:

She was not treated for the above complaints.

Family history:

She was born out of a non-consanguineous union. She is the second of three siblings. There is no history of neuropsychiatric illness in the family. Her primary attachment figure was her mother but as she became a teenager, her relations with her mother became constrained. She grew up feeling that her father was always very critical towards women and failed to understand her.

Birth and developmental history:

Details not available.

Educational history:

She has completed 12th standard after her marriage and did not study further after that. Her scholastic performance was above average. She was good in extracurricular activities such as classical dance, singing and painting. She had few friends in school and all her friendships were very shallow and short-lived.

Sexual history:

She had female gender identity with heterosexual orientation. She denied any high risk behaviour.

Marital history:

She is married for the past 2 years.

Premorbid Personality:

She was premorbidly described to extroverted. She was enthusiastic and highly motivated. She had low frustration tolerance, was known to be impulsive and had fair moral and religious standards.

Physical examination:

Her vitals were stable and her systemic examination was within normal limits.

Mental status examination

She was thinly built and nourished. She was well kempt and maintained good eye-contact. She was alert and lucid. She was cooperative towards the examiner. She was expressive and gesticulated excessively during her interview. Her facial expressions were exaggerated. Her speech was spontaneous, dramatic, and fluent with normal reaction time, garrulous productivity and normal speech. Her mood was euthymic with normal range and reactivity of affect. She denied suicidal ideation. There were no abnormalities in the form and stream of thought. Her content of thought revealed feelings of inadequacy with strong desire to prove

herself before the world; dichotomy in her appraisal of people and in her decision making and hatred towards society. She denied delusions. There were no abnormalities in her perception. She was oriented to time, place and person. Her memory was intact. Her attention could be aroused and sustained. Her intelligence was above average. She had partial insight into her problems. Her test judgement was intact while her social judgement was impaired.

Provisional diagnosis:

- Emotionally Unstable Personality Disorder -- Impulsive type
- Problems in relationship with spouse
- Problems in relationship with in-laws

Aim for psychometry:

To identify and explore significant personality factors influencing psychopathology

Tests administered and rationale for the same

1. **Sacks Sentence Completion Test**

   Rationale: It is a semi projective test developed by Dr. Sacks and Dr. Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards personal experience of life. It helps to elicit ideas of self-perception.

2. **The International Personality Disorder Examination (IPDE) - ICD 10 Module Screening Questionnaire**

   Rationale: The IPDE, developed by Dr. Armander B. Loranger and colleagues, is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders. The screening questionnaire is a tool used to eliminate individuals who are unlikely to have a personality disorder.

3. **Thematic Apperception Test**

Rationale:

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Behavioural observation:

During the entire period of assessment, she was co-operative and enthusiastic. She could comprehend the instructions and paid adequate attention. She was able to communicate appropriately. There was no performance anxiety observed.

Test findings

Sacks Sentence Completion Test

The SCT reveals her to have a poor bond with her mother. However, she feels that her mother does not appreciate her. Her relationship with her father appears strained. Although she feels that her father is a good person, she feels that he lets her down often. Her attitude towards her family as a unit appears positive. She expresses ambivalence towards her own ability. While she has a strong desire to prove herself to be equivalent with men and has confidence in her own abilities to achieve that, she also has doubts about her ability to fulfil her potential. Secondary to her doubts, she feels that the future is bleak. She feels that her ability to cope with difficult situations in life is poor and that these situations drive her towards thoughts of self-harm. She also appears to be self-critical which could be in part due to her perfectionistic nature and her high expectations and which she is unable to reach. There is guilt and regret about her discontinuation of her studies. She attaches great value on trust in her friendships and her responses reveal mistrust towards her friends and superiors in her school. Her attitude towards women is negative as she is distrustful of them and her attitude towards heterosexual relationships is mixed.

IPDE:

In the IPDE Screening questionnaire, Mrs MH's answers indicated high loading in the emotionally unstable personality traits.

TAT:

In the TAT, the stories are very detailed and long. All the stories are in the third person and she identifies himself with the heroine in most of the stories. The dominant themes of her stories are those of morality, suicide and death and most of the stories, were optimistic. The dominant needs appeared to be the needs for autonomy, dominance, achievement, recognition, succorance, affiliation, infavoidance, and counteraction. The stories also reveal a press from the environment in the form of rejection, abasement, hostility and aggression. The conflicts noted are that of achievement and autonomy.

Conclusion

The assessment indicates that she is prone to exhibit maladaptive behaviour under stressful situations. The environment was perceived threatening and insecure. The impulsive nature of her personality, low frustration tolerance and low threshold for criticism, confirm the presence of emotionally unstable personality traits.

Management

Mrs MH was admitted for psychological management and diagnostic clarification of her personality traits. Rapport was established with Mrs MH and her family members. Her cognitive errors were brought out in sessions and attempts were made at correcting them. Behavioural techniques like activity scheduling and reinforcement strategies were also employed to deal with her

personality traits. She was taught relaxation training, coping strategies and problem solving approach.

Her family was allowed to ventilate and were psychoeducated about the nature, course and prognosis of her condition. Suicidal risks and precautions were explained. Family dynamics, structure and communication patterns were explored and parents were made aware and empowered.

CASE RECORD – 2: Intelligence Assessment

Name : Miss S

Age : 7years

Sex : Female

Marital status : Unmarried

Religion : Hindu

Language : Bengali

Education : Class 1

Occupation : Student

Socio-economic status : Middle

Residence : Semi urban

Informant : Miss S and her parents

Reliability : Reliable and adequate

Presenting Complaints:

- Poor academic performance
- Inattention in school
- Illegible handwriting
- Difficulty in understanding Mathematics

History of Presenting Complaints:

Miss S was born of full term Caesarean delivery due to probable prolonged labour. There were no perinatal complications except during antenatal period. Her developmental milestones were attained age appropriately in motor, speech and language, socialization and play as described by her father. She was of an easy going temperament and was closely attached to the mother. There is no history of significant medical illness. She was able to learn the basic concepts however had difficulty in understanding number concepts. Teachers had reported inattention in class and she was easily distracted by the external stimuli. Her handwriting was illegible. She is able to perform activities of daily living by herself without prompts or supervision.

There is no evidence to suggest any psychotic or mood symptoms at the time of his assessment.

She was independent in self-care and activities of daily living.

There is no history of any psychotic symptoms in the past.

There is no history of any pervasive mood symptoms in the past.

There is no history of any anxiety spectrum symptoms in the past.

There is no history of any specific personality traits in the past.

Past & Treatment History:

There is no past history of psychiatric or significant medical illnesses.

Family History:

Her father is a medical shopkeeper by occupation while her mother is a housewife. She has a younger sister who is in play-school. Her parents had a non-consanguineous marriage. There is no family history of neuropsychiatric morbidity. There is no history of neurodevelopmental disorders in her family.

Birth and Development History:

Her birth was of a planned pregnancy with supervised antenatal period. Her mother had no complications during the antenatal period. She was born full term of Caesarean section delivery at hospital due to probable prolonged labour. Her birth weight was 3.5kg. Her neonatal period was uneventful and there were no other complications like jaundice, birth asphyxia or seizure. She was adequately immunized for age. She was not noticed to have any developmental delay by her parents.

Emotional Development and Temperament:

She was described to be an introverted, shy child with a few friends. She liked to dance.

School History:

She joined joined when she was 3 years of age. She is currently doing her 1st grade. Medium of instruction is English. She had average scholastic performance. Teachers would frequently complain of her illegible handwriting.

Occupational History:

She was a student.

Physical Examination:

Her vital signs were stable. Systemic examination was within normal limits.

Mental Status Examination:

She was well built, nourished and was appropriately kempt. Rapport could be established. She was playful and maintaining good eye to eye contacts. Her speech was spontaneous, normal intensity and tone and relevant. Her mood was euthymic with normal range and reactivity. She denied delusions, hallucinations and obsessions. She was oriented to time, place and person. Her memory was intact. Her insight was good.

Provisional Diagnosis:

Specific Learning Disorder.

Aims of Psychological Testing:

As history was suggestive of poor academic performance, IQ assessment was imperative.

Test Administered:

Binet-Kamat Test of General Mental Abilities

Vineland Social Maturity Scale

Rationale for the Test:

Binet-Kamat Test (BKT) was used to assess intelligence as it is a standardised I.Q test for the Indian population.

VSMS was used to assess for socio-adaptive functioning.

Behavioural Observations:

Miss S was cooperative for testing and was able to comprehend the simple instructions but had difficulty in comprehension of more complex instructions. She appeared quite anxious and had to be reassured periodically. She was able to sustain attention over the course of the assessment and was able to communicate adequately.

Test Findings:

On BKT, the basal age attained was 6 years, terminal age was 9 years and the mental age was 7 years and 2 months with the corresponding IQ being 101, implying average intelligence.

Function-wise Classification

Language – 8 years

Meaningful memory- 8 years

Non-meaningful memory- 8 years

Conceptual thinking- 7 years

Non-verbal thinking- 8 years

Verbal reasoning- - yet to be developed

Numerical reasoning- 6 years

Visuo-motor skills- 8 years

Social intelligence- 8 years

Scatter is seen in the assessment – her performance is good in items measuring meaningful and non-meaningful memory. However, on items that involve numerical reasoning, her performance is poor. Her social intelligence, language function, visuo-motor functions and abstract thinking was average.

Impression:

The tests are suggestive of average Intelligence

Management:

In view of the scatter profile in BKT, inattention illegible hand writing and poor number concepts, Specific Learning Disability was considered as a possibility especially due the absence of any emotional or behavioural disorders.

Parents were psychoeducated about the nature & course of her problems. Study habits and integrating various modalities and styles of learning was explained. The need for repetition during learning, for reducing academic pressure and for focussing on key topics and terms was emphasized. They were allowed to ventilate & support was provided. They were recommended for detailed curriculum based evaluation and screening for specific learning disability after 6 months.

CASE RECORD – 3: Diagnostic Clarification

Name	: Miss A
Age	: 32 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Hindi
Education	: B.E
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Urban
Informant	: Miss A, her mother and her brother

Presenting Complaints:

- Belief that she can feel sensations from her laptop on to her body
- Belief that she is a part of a military experiment
- Preoccupation
- Fearfulness
- Poor sleep

Duration:

Two years with exacerbation in the past six months

History of Presenting Illness:

Miss A was independently residing and working abroad for the past four years and was reportedly doing well till a break up in her relationship two years ago. Following the break up, she continued to function well at work and was regular to work. However, she began to notice an airplane on the sky very often when she was out on the streets. She began to experience a feeling that she was being followed by someone and rationalized it as probably someone was her admirer. Initially it did not trouble her much, but later on, she became worried when she felt that her Wi-Fi was being hacked and her personal data was being stolen from her laptop and social media accounts. She expressed this to her twin brother and was suggested to change her passwords and get a new laptop. But despite all that, the problems persisted and her suspicions grew further. She slowly began to believe that she was a part of a military experiment and that she being kept under surveillance. This belief became more firm she began to spend time reading articles about lay people being watched upon by the military and also began to associate herself with a colleague who shared such a belief system. She became very troubled and distressed and her family insisted her coming back home as she was living alone. So she, quit her job and returned to India six months ago. Her situation at grew worse as she became more and more suspicious by the day. She felt that electronic devices like her phone or her laptop emitted out electrical

impulses which she could feel on her scalp. She also began to feel a burning sensation on her ear and felt that they were reddening. As a result, she became more fearful and avoided going near them. Her sleep reduced and day by day, she was sure that she was still a part of a military experiment. She became vigilant about her health and safety. She stopped using her laptop and changed her mobile phone to an older model which did not have data connectivity option to avoid being tracked. She began to spend more time outdoors as she felt that there were less chances of her feeling electrical impulses. Her mother and her brother tried many a time to make her believe that it was all her false beliefs, but she held on to her beliefs firmly. Over the last two months, her sleep decreased and her anxiety and fear increased leading to a psychiatric consultation.

There is no history of seizure, head injury, or any other organicity, first rank symptoms, pervasive mood syndrome, obsessive compulsive phenomena, generalized anxiety or panic attacks.

Treatment History:

She has had a brief consultation with a psychiatrist in her home town and was prescribed low dose anti-psychotic medication and benzodiazepines. Due to sedation, she discontinued after a week.

Family History:

She is the second of fraternal twins to non-consanguineously married couple. Her elder twin is her brother, who is a software engineer pursuing his Ph.D. abroad. Her father works as a banker while her mother is a retired nurse. There is

no history of neuropsychiatric illness in the family. She belongs to a nuclear family.

Birth and Developmental History:

Her antenatal period was supervised and uneventful. Her birth was full term normal vaginal delivery with no birth asphyxia or perinatal complications. Her postnatal period was uneventful. All motor, social and language developmental milestones were reported to be normal.

Educational History:

She has completed her bachelor's degree in Engineering (information and technology) and her Master's in Engineering abroad. She reported to be average in studies and had good interpersonal relationship with her teachers and peers.

Occupational History:

She worked as an IT professional for a multinational corporation in India for six years and later abroad for two years.

Sexual History:

She had a heterosexual orientation and her menstrual cycles were reported to be regular. She denied any sexual dysfunction or high risk behaviour.

Marital History:

She was unmarried.

Premorbid Personality:

She was described as assertive and independent. She had difficulty in trusting people. She was responsible and meticulous in her work and day to day life. She had moderate religious standards and high moral standards.

Physical Examination:

Her vitals were stable and systemic examination was within normal limits.

Mental Status Examination:

She was thinly built and appropriately groomed. She maintained eye contact and rapport could be established. She was cooperative but defensive at times during the initial interview. She appeared tense and anxious. Her speech was relevant and coherent with normal speed, productivity and reaction time. Her mood was anxious and fearful with normal range and reactivity of affect. She denied suicidal ideations. There were no abnormalities in the form and stream of thought. Her content of thought revealed persecutory and referential delusions of the same theme. She denied hearing voices or having any perceptual abnormalities. She was oriented to time, place and person. Her attention could be aroused and sustained. She had partial insight into her illness. Her social and test judgement was intact and her personal judgement was impaired.

Provisional Diagnosis:

- Delusional disorder
- Paranoid Schizophrenia
- Paranoid Personality Disorder

Aim for Psychological testing:

To clarify symptomatology, psychopathology and diagnosis

Tests Administered:

1. Sack's Sentence Completion Test
2. Rorschach Inkblot Test
3. NEO-FFI
4. Brief Psychiatric Rating Scale (BPRS)

Behavioural Observation:

She was cooperative over the course of the assessment. She was able to comprehend the instructions well. There was no performance anxiety observed. She tended to elaborate answers often

1. Sacks Sentence Completion Test

Rationale:

Sacks Sentence Completion Test is a projective test developed by Dr. Sacks and Dr. Levy. It consists of 60 partially completed sentences to which the

respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test Findings:

The SCT reveals her to have a strong dependency on her mother. She idolizes her mother however feels that her mother wants to have a son rather than her. The main emotion that she attaches to her father is respect and is dissatisfied with the amount of time he gets to spend with her. Her attitude towards her family as a unit appears positive. She expresses ambivalence towards her own ability with regards to academic but she is very confident that she will reach her full potential. She regards her past as a happy one; however, she has doubts about her future. She perceives people as being supportive to her. Her attitude towards women is negative as she feels that women are mostly interested in external appearance. She had mixed feelings regarding heterosexual relationships.

2. Rorschach Ink Blot Test

Rationale:

Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Test Findings:

In the Rorschach protocol, she has given 20 responses indicative of low productivity. The protocol also indicates quick and hurried mentation. She has a tendency towards impulsivity but at times is able to repress her impulses. There is an underdeveloped need for affection which may result in a lack of personal involvement in interpersonal interactions without a threat to the stability of the personality as a whole. There is a tendency towards withdrawal from others due to possible past traumatic events. The high D% indicates a tendency towards rigidity and a sense of insecurity. There is a neurotic constriction seen indicative of her tendency to inhibit her natural response in favor of socially desirable ones. She has a tendency to be ambitious even at the expense of other important satisfactions. Variety in content is indicative of good intellectual capacity. Low number of popular responses indicated impaired reality testing. The low number of human responses indicates her tendency towards social withdrawal and difficulty in trusting people.

3. Neo Five Factor Inventory Questionnaire

Rationale:

The NEO-FFI is a 60-item test. It provides a quick, reliable and accurate measure of the five domains of personality and is particularly useful when time is limited and when global information on personality is sufficient.

Test findings:

In the NEO FFI, she scores high on openness, and average on neuroticism, extraversion, agreeableness and conscientiousness. It indicates that her curiosity is high and she is adventurous and is more willing to do different activities and visit new places than others. She is open to novel ideas and unconventional values. She tends to experience deeper and more differentiated emotional states than others do. She tends to feel frustrated and angry easily but it's not pervasive and is able to revert back to normalcy. She is described as being average in controlling her impulses and desires.

She tends to be sociable, assertive, active and talkative. She is sympathetic and eager to help others and to be only helped in return. She is also purposeful, strong-willed, determined and with a sense of achievement.

4. Brief Psychiatric Rating Scale

Rationale:

The BPRS is a rating scale developed by Gorham and Overall designed to measure psychiatric symptoms. It rates the severity of a variety of psychiatric symptoms between 1 to 7.

Test Findings:

Her total score on the BPRS at admission was 46. She had high scores in the areas of somatic concern, anxiety, unusual thought content and suspiciousness. At discharge her total BPRS score had reduced to 29.

Summary of Test Findings

Assessment indicated the presence of impaired reality testing suggestive of a psychotic process. However, the absence of other indicators of schizophrenia and intact overall personality structure was suggestive of a delusional disorder.

Final Diagnosis:

Delusional disorder

Management:

She was admitted for diagnostic clarification and appropriate treatment. Clarification revealed the presence of a well systematised single delusional theme with acting out behaviour and hallucinatory experiences in keeping with the delusions. Pharmacologically she was given the options of Risperidone versus Olanzapine after discussing the benefits and risks of each drug. She opted for Olanzapine and the dose was titrated up to 25mg/day.

Behaviour analysis of her symptoms showed that her sensations occurred more when she was distressed or upset. Cognitive distortions of overgeneralisation and jumping to conclusions were recognised. Alternative explanations to her beliefs were explained and gradually, she was able to accept them. She restarted using the electronic devices which she previously avoided. The mother and brother were educated about the nature of the illness, its course and prognosis as well as for the need of regular follow-ups, compliance and supervision of medications.

CASE RECORD –4: Diagnostic Clarification

Name : Dr. S

Age : 38 years

Sex : Male

Marital status : Married

Religion : Muslim

Language : Malayalam

Education : MD (Radio diagnosis)

Occupation : Radiologist

Socio-economic status : Upper

Residence : Urban

Informant : Dr. S and his parents

Presenting Complaints:

- Anxiety in social situations
- Repetitive thoughts of harm to self by others for unknown reason associated with fear
- Suicidal thoughts
- Decreased socialisation
- Socio-occupational decline

- Decreased sleep and appetite

Duration: 17 years

History of Presenting Illness:

Mr. S was reported to be shy individual; who preferred to be alone; had few friends and had a tendency to worry excessively about trivial issues. He was able to function adequately despite these traits and they did not interfere with his functioning significantly. He performed well scholastically and although he had a tendency to avoid socialization, he was able to socialize appropriately when required.

During his MBBS course, following an unrequited relationship with a colleague, he started becoming reclusive as his colleagues found out and began to tease him about it. Gradually, he began to feel distressed and henceforth avoided any social situations. He became more and more anxious in social situations and he began to experience palpitations, tremors, profuse sweating during these situations. This progressively worsened and he started missing classes and other social events over fear of doing anything embarrassing. During his summer break, he refrained from visiting his relatives at family gatherings. When forced, he would remain secluded in a corner, not engaging in any conversation with other people. His anxiety grew to a point where he began to stammer resulting in further social withdrawal and avoidance.

Gradually, he began to avoid classes and clinics resulting in academic decline and a lack of attendance due to which he was unable to complete his course in the stipulated time period.

He also expressed fear that even unrelated people were looking at him and talking about him when he was at any public place and also misinterpreting the actions of neighbours to be motivated by ill-feelings against him. These worries were not held by his family members. He was married in 2010 and faced problems in his marital life as well. He would get in to frequent arguments with his wife as he had difficulties in taking decisions and was unable to help with chores in the house. He also felt that his wife never understood him or his problems, and, as a result felt very inadequate.

There is history of nicotine use in dependence pattern

There was no history of harm to self or others.

There is no history of seizure, head injury, or any other organicity.

There is no history of any first rank symptoms.

There is no history of any pervasive mood syndrome.

There is no history of any obsessive-compulsive phenomena.

Treatment History:

No prior history of taking treatment for the above.

Family History:

He is the second of twins, born to his parents from a non-consanguineous union. There is family history of probable mood disorder in the paternal grandmother and cousin, and a depressive illness with psychotic symptoms in his mother. There is also a history of completed suicide in the maternal cousin. His father is a General Practitioner and his mother is a homemaker. His older twin is an anaesthetist, his younger brother a Radiation Therapist and his youngest sister is preparing for her medical entrance exams.

Birth and Developmental History:

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or perinatal complications. Postnatal period was uneventful. Both motor and language developmental milestones were reported to be normal.

Educational History:

He has completed his MD in Radio-diagnosis. His academic performance was reported to be good. He had good interaction with his peers and teachers until the onset of his symptoms during his under graduation in Medicine.

Sexual History:

He has male gender identity and heterosexual orientation. He denied any high risk sexual behaviour. He reports to have a low libido.

Marital History:

He is married for the past six years to Ms J, who is thirty-two-years-old and is a gynaecologist by profession. They have two children, a girl and a boy aged five years and two years respectively.

Premorbid Personality:

Premorbidly he is described to have feelings of inadequacy and was socially inhibited. He was sensitive to criticism and had difficulty accepting it. He had a tendency to brood over things and was pessimistic in his outlook. He consumed alcohol occasionally and smoked cigarettes in a dependence pattern.

Physical Examination:

His vitals were stable and systemic examination was within normal limits.

Mental Status Examination:

He was moderately built and adequately kempt and maintained poor eye contact. Rapport was established. He had retardation in his level of activity. He was tense and anxious, sweating profusely and had tremors of both his upper extremities. His speech was spontaneous, relevant, monotonous, with increased reaction time, decreased speed and laconic productivity. His mood was anxious and dysphoric with restricted range and decreased reactivity. He admitted having suicidal ideations but no active suicidal planning. There were no abnormalities in the form and stream of thought. His content of thought revealed referential ideas, feelings of low self-esteem and self-worth. There were no thought alienation

phenomenon. He denied the presence of perceptual abnormalities. He was oriented to time, place and person. His immediate , recent and remote memory were intact. His attention could be aroused but was difficult to sustain due to his anxiety. His intelligence was average. His social judgement was impaired while his test judgement was intact.

Differential Diagnosis:

1. Anxious avoidant Personality Disorder
2. Paranoid schizophrenia

Aim for Psychometry:

To clarify symptomatology, psychopathology and diagnosis

Tests Administered and their rationale:

1. **Sack's Sentence Completion Test**

   Rationale: It is a projective test developed by Dr. Sacks and Dr. Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

2. **Thematic Apperception Test**

   Rationale: is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to

ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

3. **Rorschach Inkblot Test**

   Rationale: Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis- if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Behavioural Observation:

He was cooperative to do the assessment. He was able to sustain his attention over the course of the assessment. There was slight performance anxiety observed but was able to overcome those with persuasion and encouragement. He was able to communicate without any difficulty.

Test Findings:

Sentence Completion Test

The SCT reveals him to have a strained bond with his mother and father. Although he feels that his father is a good person, he feels that he lets him down often. His attitude towards his family as a unit appears negative. He has doubts about his ability to fulfil his potential. Secondary to his doubts, he feels that the future is bleak. He feels that his ability to cope with difficult situations in life is poor and that these situations drive him to be alone. He also appears to be self-critical which could be in part due to his approval seeking nature and his high

expectations and which he is unable to reach. He attaches poor value on trust in his friendships and his responses reveal mistrust towards his friends and superiors in his school and college. His attitude towards women is negative as she is distrustful of them and his attitude towards heterosexual relationships is mixed.

Thematic Apperception Test:

In the TAT, the stories are very detailed and long. All the stories are in the third person and he identifies himself with the hero in most of the stories. The dominant themes of his stories are those of morality, suicide and death yet most of the stories, were pessimistic. The dominant needs appeared to be the needs for autonomy, dominance, achievement, affiliation, counteraction and sex. The stories also reveal a press from the environment in the form of rejection, abasement, hostility and aggression. The conflicts noted are achievement and autonomy versus harm and blame avoidance.

Rorschach Ink Blot Test:

On the Rorschach protocol, he has given 16 responses indicative of low productivity and the average time taken for each card indicates an average mentation. Low M responses and lack of FM responses indicates that the impulses are such a threat to the ego that they are not acknowledged by the individual and he tends to repress them. The protocol indicates a high need for affection, that fear of being rejected or hurt results in inhibition of his overt reaction to others. There is a neurotic constriction indicating that although he is

capable of responding adequately to the environment, he tends to inhibit such a response due to his need to repress his emotional reactions. He tends to be inhibited in situations that he tends to perceive as threatening and he tends to be disturbed by emotional impact from the environment. Due to his inhibitory nature, he tends to stick to a practical common sense approach. Low number of popular responses indicated poor ties with reality. High Animal responses indicates a tendency to look at things in a stereotypical manner and adjustment difficulties.

Low number of responses, rejection of cards, increased D% indicate depression and variation in reaction time, colour disturbance and blood responses indicate the presence of anxiety.

Summary of test findings:

Both projective and objective assessment indicated the presence of low self-esteem, feelings of inferiority, pessimism, pervasive anxiety and poor social skills which are indicative of anxious avoidant personality disorder. There were no indicators of psychosis or pervasive mood syndrome.

Final impression:

Anxious Avoidant Personality Disorder

Management:

He was admitted for diagnostic clarification and appropriate treatment. Initially he was started on Olanzapine at 5mg/day but as the psychotic symptoms were clarified and ruled out over time it was gradually tapered and stopped. Fluoxetine was added at 40mg per day in view of prominent anxiety symptoms. He showed significant improvement with this.

Non-pharmacological measures were also employed like Cognitive-behavioural strategies to reduce depressive and anxiety symptoms. He was taught relaxation strategies like Jacobson's Progressive Muscular Relaxation and Deep Breathing Exercises. An activity schedule was given for his day to day routine work. He was engaged in Occupational Therapy during the hospital stay. He was part of the social skills training group. He was psychoeducated about the nature, course and prognosis of illness. Marital issues with patient and wife were discussed during sessions where both were allowed to ventilate. Common goals were set and methods to improve communication were agreed on.

The family were allowed to ventilate and the nature of his problem was explained to them. Their distress was acknowledged and they were supported.

Case Record-5: Neuropsychological Assessment

Name	: Mr MS
Age	: 68 years
Sex	: Male
Marital status	: Married
Language	: Hindi
Education	: Veterinary Sciences
Occupation	: Retired
Socio-economic status	: Middle
Residence	: Semi-urban
Informant	: Self

Presenting complaints:

- Forgetfulness
- Memory disturbances
- Low mood

Since last 10 years

History of presenting complaints:

Dr MS, an elderly retired gentleman, presented with complaints of a progressive decline in his memory for the past 2 years. He stated that initially, it was restricted to remembering names of people he had newly met. But gradually, it extended to not remembering their faces. This led him to a couple of embarrassing situations in social events. He also stated that he would forget where he had kept his belongings at home, and would often spend a lot of time searching for his misplaced items. This would lead him to be very frustrated and tensed. He also had difficulty in calculating bills and would recheck them again and again. Plus, he would frequently note down new pieces of information, in case he would forget. On one occasion, he forgot where he had kept his bank passbook and had to get a new one issued, only to be found later in his almirah. He did not report of any instances of losing his way home, however, he did admit to forgetting the directions to the places he commonly visited, like the temple. All the above problems began after the death of his wife 2 years ago, when he started staying alone.

There is no history of fever or trauma.

There is no history of any first rank symptoms of schizophrenia.

There is no history of manic, hypomanic or depressive symptoms.

There is no history of obsessive-compulsive symptoms or panic symptoms in the past.

There is no history of any other specific personality traits.

Past history:

There is no history of medical co-morbidities.

Family history:

There is history of probable psychosis in the brother. No history of seizures, substance use or suicides present.

Birth and development history:

Details are not available

Educational history:

He has a degree in Veterinary Sciences and was reported to have above average in scholastic performance.

Occupational history:

He worked in the Government Services for the past 34 years and retired 6 years back. He was noted to be diligent and efficient.

Sexual history:

He was of heterosexual orientation.

Marital history:

He was married to Lt Sudha Devi and has three sons. He preferred to live alone but occasionally stayed with his eldest son.

Premorbid personality:

He is described to be well-adjusted with no deviant personality traits.

Physical examination:

His vitals were stable and systemic examination was within normal limits. There were no focal neurological deficits.

Central Nervous System Examination:

Higher Mental Function- MMSE 29/30

Cranial Nerves- No cranial nerve palsies

Motor System:

Bulk- Normal in all muscle groups

Tone- Normal in all muscle groups

Power- Grade 5 power in all four limbs

There were no involuntary movements

Sensory system:

Crude touch, Pain, Temperature- normal bilaterally

Fine touch, Vibration sense and Joint position Sense- normal bilaterally

Reflexes:

Superficial abdominal reflex- present in all four quadrants

Plantar reflex- flexor bilaterally

Deep tendon reflexes- 2+ bilaterally

Cerebellar functions- no signs of cerebellar dysfunction

There were no frontal release signs

Gait- normal

Signs of meningeal irritation- absent

Skull and spine- normal

Mental Status Examination:

He was well built and nourished. Rapport could be established. He made good eye-contact. His speech was spontaneous and relevant with hoarseness of voice. His mood was euthymic with normal range and reactivity. There was no formal thought disorder. He denied having any perceptual abnormalities. He was oriented to time, place and person. His immediate, recent and remote memory were intact. His attention was arousable and sustainable. His intelligence was average. His insight and judgement was not impaired.

Differential diagnosis:

- Mild Cognitive Impairment
- Pseudo dementia
- Dementia of Alzheimer's disease with late onset

Aims for neuropsychological testing:

- To assess cognitive profile of Mr MMS
- To correlate findings to clinical profile
- Plan further management according to cognitive functioning

Tests Administered and Rationale:

- **NIMHANS Neuropsychology Battery (2004)**
- **Rationale:** The battery was developed by Shobini Rao et al. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population.

Behavioural Observation:

He was initially cooperative for the assessment but had difficulty in sustaining his attention over the course of the assessment. Therefore, the assessment had to be held over multiple sessions. Although, there was no active resistance in doing the assessment, he required frequent reassurances and encouragement to complete and persist with the assessment. He tended to give up easily and despite repeated encouragement, did not complete a few subtests or did not perform them with interest. He was able to comprehend the instructions well. His verbal communication was adequate. There was no performance anxiety observed.

TEST RESULTS:

NIMHANS Neuropsychological Battery

Mental speed

On the digit symbol substitution test, the total time taken to complete was 277s which is below the 18th percentile.

Sustained attention

On the digit vigilance test, total time taken was 700s, which is at the 10th percentile, with the number of errors being 7, which indicates 28th percentile.

Focussed Attention

On the Colour Trails Test 1, the total time taken to complete was 206s which is below the 3rd percentile and the total time taken to complete Colour Trails Test 2 was 260s which is also below the 6th percentile.

Divided Attention

On the Triads Test, the total errors were 4, which is at the 56th percentile. He was able to focus his attention on the tasks he was instructed to do.

Executive functions:

- **Phonemic fluency**

  Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average number of new words generated was 17 which is at the 95th percentile.

- **Categorical fluency**

  Was assessed by the Animal Names Test. The total new words generated was 13, which is at the 40th percentile.

- **Working memory**

  Working Memory was assessed using the Verbal N back Test. The number of 1 back hits was 8 and errors was 2 which is at the 5th and at the 18th percentiles respectively. The number of 2 back hits was 6 and errors was 4, which is at the 10th and at the 34th percentiles respectively.

- **Planning**

  Planning was assessed by the Tower of London Test. The total number of problems solved in the minimum number of moves is 12, which is at the 90th percentile. The mean time taken, the mean moves and the number of problems with minimal moves are as follows,

No of moves	**Time taken**	**Percentile**	**Mean moves**	**Percentile**	**No of probe with minimal moves**
2 moves	6s	**20th**	2	**100th**	2
3 moves	14s	**33th**	3	**100th**	3
4 moves	15s	**57th**	4	**100th**	4
5 moves	14s	**97th**	5	**100th**	3

Verbal Learning and Memory:

On the auditory verbal and learning test, the total number of correct words recalled is 50, which is at the 75th percentile; the immediate recall and delayed recalls are at 5 and 8 words which are at 10th and 30th percentile respectively. The long term percentage retention is 110%. The number of hits in the recognition trial is 13 which is at the 20th percentile.

Visuo - spatial construction and visual learning and memory:

On the ROCF, the copying score is 32, which is at the 30th percentile. The immediate recall score is 16 which is at the 30th percentile and the delayed recall is 18 which is at the 40th percentile.

Impression:

The neuropsychological assessment revealed deficits in the mental speed, sustained attention and focussed attention. However, there were no deficits in the divided attention, executive functioning, verbal learning and memory and Visuo - spatial construction and visual learning and memory.

Management:

An impression of Mild Cognitive Impairment was considered. Reversible causes of dementia was ruled out. Since Mr MMS was staying alone after the death of his wife, a grief response was also considered. However, he did not fulfil the criteria of a depressive episode requiring pharmacological intervention. Techniques like eating healthy and exercising regularly, having a good night's sleep, playing games like crossword puzzles or Sudoku and trying mnemonic methods were suggested to improve his memory.